# Rowan-Salisbury Schools

## EMERGENCY SPORTS MEDICINE RECORD

STUDENT NAME _____ DATE OF BIRTH_____

HOME ADDRESS_____

HOME TELEPHONE NUMBER_____

PARENT'S/GUARDIAN NAME_____

ADDRESS (IF DIFFERENT FROM ABOVE)_____

HOME TEL. NUMBER (IF DIFFERENT FROM ABOVE)_____

BUSINESS TELEPHONE NUMBER_____

CELL TELEPHONE NUMBER_____

EMERGENCY CONTACT (PERSON OTHER THAN PARENT/GUARDIAN)

_____ TELEPHONE NUMBER_____

NAME OF FAMILY DOCTOR_____TELEPHONE NUMBER_____

HOSPITAL PREFERENCE_____

NAME OF INSURANCE_____

POLICY NUMBER_____

CURRENT MEDICATIONS (If Any)_____

MEDICATION ALLERGIES (If Any)_____

PAST ILLNESSES AND DATES:_____

_____

PAST INJURIES AND DATES:_____

_____

**Release for Emergency Medical Treatment**

**In the case of injury or illness, I give permission for my son/daughter _____**

**to receive emergency medical treatment if necessary.**

**Parent or Guardian Signature: _____ Date:_____**

**Parent or Guardian Signature: _____ Date: _____**